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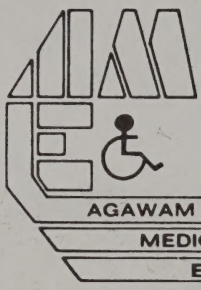

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Annual Meeting Of The Hampden District Medical Society

PLACE: STORROWTON TAVERN, The Barn
West Springfield, Massachusetts

DATE: Tuesday, April 29, 1980

BUSINESS MEETING
SOCIAL
HOUR: 6:00 P.M. - 7:30 P.M.

ELECTION OF OFFICERS: Report of Nominating Committee

DINNER: 7:30 P.M.

SPEAKER: Thomas M. Reardon, Esq.
Warner & Stackpole, Boston, Massachusetts

TOPIC: "Legal Challenges Facing Physicians Today"
Spouses are invited to attend this meeting.
Dinner for members, courtesy of HDMS
Dinner for guests $10.00
Please remit check with reservation.

Note:
If you must cancel your dinner reservations, call the office before noon on April 29, 1980. If the cancellations are not made you will be billed for your dinner.

Smoking in designated areas only at dinner.

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I shall attend the meeting at Storrowton Tavern
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MARCH 1980 VOL.XXXVI-NO.3

Contents

To Learn From The Ills of Others 6
Franco Navazio, M.D.
President

Hyperkinesis & Stimulant Medication 10
Mathew R. Friedman, M.D.

Orthopedic Screening 13
Garry Hough, III M.D.

The Scarsdale Diet 16
Harrison D. Willcutts, M.D.

Proposals for Federal Health Care Plans 19
Carl Janovsky, M.D.

Pediatric Reflections of Child Abuse One Man's View 23
Paul Taylor

Executive Committee 27
William W. Walthall, M.D.

By-Law Changes 29

The official bulletin for The Hampden District of The Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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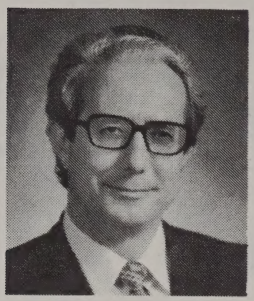

PRESIDENT'S PAGE

To Learn From The Ills Of Others

In Rome, Italy, hospitals explode and unbelievable phenomena occur in dramatic sequence: Inpatients already admitted block the entrance of new ones for lack of space; patients upset by long waits or improper bed assignments will throw their beds (with linens and mattresses) out of the hospital windows; carbon dioxide tanks are exchanged with oxygen tanks which cause consequent death of patients due to...technical error; a.s.f.

The Italian capital reflects the profound dysfunctions which appear in the whole health delivery system of the Italian Republic. This system is extremely expensive and loaded with debts.

What are the reasons for all of this and what should the remedies be? In Italy, the ratio of hospital beds to population is adequate and surely not inferior to the average European level. The number, of physicians assigned to different services is superior and the highest in Europe. There is an overwhelming pletora of administrative personnel and poorly qualified nursing personnel. The rate of absenteeism is excessive in all categories.

Physicians have no incentive to shorten hospitalization periods. Each one must demonstrate that beds in his department are fully utilized, hence no patient is discharged until others come. As a conclusion, the celerity of hospital services is soon forgotten and weeks and months are needed for appropriate work up of even common entities.

On January 1st the "Health Reform" institution the National Health Service has been enforced. Now, nobody knows anymore who is in charge. Hospital administrations should report to local regional health councils which should report to the centralized Ministry of Health. Practically, the deficit of commands has accentuated the degeneration of the hospitals.

Since January 1st, everbody in Italy has the right to receive health care for nothing. Hence, since January 1st, the request for hospital admissions jumped 10%. Patients from peripheral areas or regions think that by going to the city hospitals or so called "big centers" may indeed find the best specialists there, and the system would work if non serious patients of the city could be sent without any objection to the secondary hospitals of the periphery or of the country, but of course this does not happen.

Italians, on the other hand, depend too much on the health service. They want everything for nothing. I, personally, do not understand why they are so ready to spend enormous amounts for exclusive automobiles or color televisions but so greedy that they won't even touch their wallets in order to defend their health.

What should we learn? We, even here, think that the "law" may be like a magician's stick. It is not so. We can not create jobs, nor reset a faultering industry. At the same time, neither can we guarantee health laws.

From this analysis, a sort of treatment may emerge. A key point is that the hospital must be thought of as a "plant" which receives sick people and tries its best to return them back healthy in the shortest possible time and in the most economical way. From this, we reach the conclusion that good delivery centered in and around hospitals, needs managerial incentivesness and technical decisional powers.

This is impossible when we deal with simplistic social requests and excessive stratification of corporative powers.

In this area, we should stay away from bureaucratic carbon dioxide and give instead managerial oxygen to our health structures. □

FRANCO NAVAZIO, M.D.
President

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In Memoriam

EDWARD J. MC HUGH
1906 - 1979

Edward John McHugh died in his sleep at 50 Pleasant Street, Holyoke, on November 29, 1979.

He was born in Holyoke on May 4, 1906. He attended Sacred Heart High School where he graduated in 1923. He was an outstanding football player at high school and at Holy Cross College from which he graduated in 1927.

He attended Tufts College Medical School where he received his medical degree magna cum laude in 1931.

He served his internship at Worcester City Hospital from 1931 thru 1933. It was during this period that he married Catherine Delaney who died in 1972.

In 1933 he opened his office and served as City Physician from 1935 thru 1938. He was a member of the staffs of Holyoke Hospital and Providence Hospital. At the latter hospital he served as president of the medical staff and for five years served as Chief of Surgery.

He entered the U.S. Navy in 1942 and was discharged with the rank of Lt. Commander in 1946. He participated in the invasion of Africa and later in many invasions in the Pacific Theater of War.

He was a member of the Hampden District Medical Society, The Massachusetts Medical Society, and the A.M.A. He was a fellow of the American College of Surgeons.

Dr. McHugh leaves his wife, the former Ruth Rosazza, and three sons, Dr. Edward D. McHugh, the present Chief of Surgery at the Providience Hospital, Dr. John E. McHugh, Chief of Respiratory Service at the Providence Hospital and Attorney David M. McHugh of Fairfield, Connectiut and nine grandchildren.

These few words and statistics fall far short of describing the value and greatness of this man. His surgical talents aided many of his fellow physicians and enabled many younger men to gain competence in surgical skills. His kindness and compassion proved beneficial to countless thousands in the city of Holyoke. His passing leaves a vacuum which will defy filling. He made the lives of all who knew him much richer and his passing will leave many of the physicians in Holyoke saddened. □

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JOHN J. DRISCOLL, M.D.

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Hyperkinesis and Stimulant Medication

According to the Diagnostic and Statistical Manual of Mental Disorders, second edition (DSM-II), the hyperkinetic reaction of childhood or adolescence is "characterized by overactivity, restlessness, distractibility, and short attention span, especially in young children; the behavior usually diminishes in adulthood." In DSM-III, this diagnosis is included as an "Attention deficit disorder with hyperactivity." Over the years, many terms, including 'Minimal brain dysfunction,' have been employed to describe the cluster of signs and symptoms associated with the hyperkinetic child, and there is an ongoing debate over diagnosis which is likely to continue. Meanwhile, those who work with children commonly encounter youngsters who demonstrate hyperactive behavior, impulsiveness, learning difficulties, emotional liability, poor frustration tolerance, poor impulse control, and who require the service of professionals for many disciplines.

Estimates on prevalence of the hyperkinetic syndrome tend to vary between 4% and 10% of elementary-aged children, with males receiving the diagnosis four to ten times more frequently than females. While it appears that hyperkinesis tends to diminish with age, there is accumulating evidence that many of these children continue to show academic, conduct, and self-image problems so that although the symptom pattern changes, the disorder does not remit.

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The evaluation and treatment of hyperkinetic children is a multidisciplinary effort. The clinician typically requires developmental and social history from parents, reports from classroom teachers and other school personnel, and observations in an office setting. Psychometric testing, specialized educational assessment, and neurological examination are frequently integral parts of the evaluation. Implementation of treatment programs frequently involves the coordination of many individuals.

There are many facets to the treatment of hyperkinetic children. These typically include special education, environmental manipulation, psycho-therapy or counselling, and the use of stimulant medication, especially dextroamphetamine (Dexedrine) and methylphenidate (Ritalin). The role of drugs in the treatment of disturbed children has been a controversial subject. Opponents have claimed that psychotropic drugs act only as ''chemical straightjackets'' and discourage recognition and treatment of the true psychopathology within the child or family. Others have viewed medication as the only treatment with specificity and demonstrated efficacy. There is considerable data to demonstrate the usefulness of stimulants in children diagnosed as hyperkinetic, and there is general agreement that at least for the short-term they tend to increase attention and diminish impulsivity. It must, however, be emphasized that, while stimulant medication may be a useful adjunct in treatment, it is by no means sufficient by itself and should be accompanied by re-medical education, parent guidance, and continuous clinical observation, along with proper monitoring and follow-up.

The long-term usefulness of psychotropic drugs is less well-established. Common side effects of stimulant medications include anorexia, stomachaches, rebound irritability, and insomnia. There has been some concern as to whether these drugs inhibit growth and diminish weight gain, but these effects, when they occur, are likely a result of diminished appetite, and cessation of medication may lead to a compensatory growth spurt. To minimize the side effects, it is commonly recommended that children be given a ''drug holiday'' from mehtylphenidate and dextroamphetamine on weekends and during school vacation periods. This may also help diminish the development of tolerance to the medications. Despite concerns about the development of drug abuse or dependency in the long-term, available studies do not demonstrate that this occurs.

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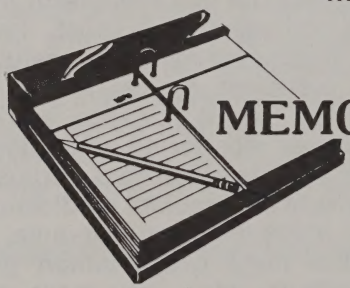
In summary, stimulant medication is useful in the treatment of many hyperkinetic children. Some children clearly benefit more than others, and careful diagnostic evaluation is essential. It is important to take into consideration all aspects of the child's environment. The American Academy of Pediatrics' Council on Child Health (1975) concluded that "there is a place for stimulant drugs in the treatment of hyperkinetic children. Moreover, such drug therapy in properly selected individuals does not constitute 'constraint of freedom.' Rather, it is the child's restlessness, distractibility, and impulsivity that are the constraints. Proper selection of patients is perhaps the key factor. In addition, monitoring and follow-up are necessary. Monitoring of hyperkinetic children at school must imply cooperation with any by principals, teachers, guidance counsellors, and school physicians and nurses. The overall management of school failure may well be a multidisciplinary venture, but the ultimate responsibility for chemical behavior modification is the physician's. Assuming such responsibility requires the physician to avail himself of the accumulated knowledge of the subject, a sound principle in any therapeutic undertaking." □

MATTHEW R. FRIEDMAN, M.D.



MEMORANDUM

TO: Members of Hampden District Medical Society

FROM: JAMES J. SIRAGUSA, JR., M.D. President-Elect

SUBJECT: If you care to work on a committee for the year 1979-1980, please notify Mrs. Purdy at the central office.

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Orthopedic Screening

The examination of large numbers of asymptomatic individuals for potential disease is attracting more and more attention. At a time when general screening in the form of the "annual physical examination" is being challenged as cost ineffective, more and more effort is being expended in disease-specific screening. The idea is not new. Skin testing for tuberculosis dates back to 1890 and is still useful in selected populations. More and more tests are now available for the detection of specific illnesses. The list of orthopedic conditions in which screening is appropriate is somewhat shorter than for other specialties. They involve primarily diseases affecting children and the screening is largely carried out by individuals other than orthopedic surgeons. For these two reasons it seems useful to review orthopedic screening procedures here.

The many problems affecting medical screening, such as selectivity, specificity, the utility of prognostication and cost benefit ratios will not be discussed, as there is considerable literature available on the subject. I must reemphasize that screening should not be undertaken without a well-organized program to deal with the medical, social and emotional consequences and to provide adequate follow-up. I would like to divide orthopedic screening into preconception, prenatal, infantile and childhood.

Genetic counseling has graduated from fatherly advice to a specialty in its own right. Many of the conditions with predictable genetic patterns have skeletal manifestations either as a primary or associated manifestation. There is a long list of relatively rare conditions with clearout autosomal or sex linked dominant or recessive inheritance which allow accurate statistical prediction. More commonly, multifactorial traits such as club foot, myelodysplasia and hip disorders allow some prediction of risk. With a family history of one of the these conditions, genetic counseling is appropritae and is now available in many clinics in Springfield and Western Massachusetts. This is particularly important when parents of an affected child are considering having further children. It must be remembered that these opinions are purely advisory and are never absolute. The final decision must always rest with the parents.

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Prenatal diagnostic testing is becoming increasingly valid. Orthopedic conditions do not take the forefront, but skeletal abnormalities are often a part of the syndromes under consideration. Particular interest is currently being generated by the prediction of neural tube defects by alpha-fetoprotein determination. Although precise fetal age determination and strict quality control standards limit the availability of this measurement as a screening test, the personal and social costs of myelodysplasia (2.24 neural tube defects per 1000 births in Massachusetts) are so high that positive cost benefit ratios seem likely. Fetal karyotyping offers diagnostic potential, notably in Down's syndrome. Under these circumstances, disease prevention requires abortion with all its moral and emotional overtones. It would appear that parental preparation for major disability of their expected child is a positive benefit for those parents who decline abortion for personal reasons. Intelligent decisions cannot be made without accurate information. Teratogenesis has also been of orthopedic interest since the recognition of thalidomide as a cause of limb deficiency. An increasing incidence of congenital amputees has been recognized in this country over the past 20 years lending support to the theories that agents other than thalidomide are abroad in the land. I would like to reemphasize that the social costs of congenital malformations are very high and that prevention will pay more dividends.

Neonatal orthopedic screening falls entirely to the pediatrician. The importance of the postnatal examination and repeated evaluation of the well baby are firmly established. Prompt attention to skeletal disorders of the newborn are the rule rather than the exception. For conditions such as limb deficiency, myelodysplasia and other conditions not prevented by the techniques are discussed above, early detection institutes a lifetime of orthopedic care. Even here, prompt treatment can minimize secondary skeletal, developmental and social deformities. Some muscular conditions such as torticollis respond rapidly to early conservative treatment but require surgery if ignored. Arthrogryposis, long the bane of the pediatric orthopedic surgeon, has a much improved prognosis with the early institution of frequent passive joint manipulation. Club foot responds best to treatment within the first week of life. Nowhere is early detection more important than in congenital dislocation. Knee dislocation is quite obvious, but detection is more subtle in congenital dislocation of the hip. Present theory states that multiple factors render certain hips ''dislocatable'' at birth. This can be detected by the well known Ortolani, Barlow and Allis' signs. Many of these hips become stable spontaneously but thisprocess is facilitated by keeping the infants in abduction. About 10 in each 1,000 live births show

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this abnormality, which often cannot be confirmed by x-ray. Perhaps 90% stabilize spontaneiously since the classic incidence of congenital dislocation of the hip was 1:1,000 when the diagnosis was made radiographically at six months or later. Neonatal dislocatable hips respond uniformly to appropriate bracing unless they are "teratologic", i.e., associated with generalized skeletal disease. Delay in diagnosis beyond three or four months of age greatly increases the risk of permanent disability. Specific details of examination and treatment are readily available.

Orthopedic screening of the school age child has been carried on for a generation or more in a general way. Annual school physicals produced a large number of notes carried home to parents criticising the child's "flat feet" or "poor posture". Neither condition represented a specific orthopedic disease and very little benefit resulted from this activity. More recently programs have been developed to detect a specific childhood disorder, scoliosis. Although scoliosis can appear at any age and has a variety of causes,the most prevalent form is idiopathic scoliosis appearing during adolescence. Although the traditional incidence of scoliosis is two or three per 1,000 population, a properly conducted survey of 1,000 seventh grade children will reveal about 50 children with some degree of spinal curvature. Only 10% of these (0.5 per thousand) will be bad enough to require treatment when initially seen. Approximately 3 per thousand will get worse under observation. It is necessary to follow all 50 patients with minor curves in order to detect which 3 require bracing. Essentially all children whose scoliosis is detected in this fashion will respond to conservative (brace) treatment. The total cost of screening, follow-up, and brace treatment for these thousand children will be about $4,500 (1976 study). Without this screening probably one child per thousand would require surgical correction at a cost in excess of $10,000. Although a good scoliosis screening program requires the cooperation of orthopedic surgeons, pediatricians, family physicians, school physicians, nurses, teachers and parents it can save the community an appreciable amount of health care costs, and nearly eliminate the need for surgical treatment of scoliosis. At the same time juvenile kyphosis (Scheuermann's disease) can be detected at no extra cost. Most of our suburban communities have instituted such programs and it seems unfortunate that Springfield school children are not similarly served.

In summary, early detection of specific diseases is applicable to certain orthopedic conditions as it is in other fields of medicine. Although considerable organization and effort is necessary, patient outcomes are superior and total health costs are decreased by such programs. □

GARRY HOUGH, III, M.D.

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The Scarsdale Diet

The remarkable advances in the science of nutrition were once again detailed and extolled this month in Washington. The HEW sponsored international gathering on "Where Are We Going with Nutrition in the 80's was both exciting and distriessing. Dr. Stanley Dudrick, Professor of Surgery at the University of Texas called the lack of attention paid to nutrition "one of the most shameful shortcomings of American medicine today". He repeated his testimony to Senator McGovern's sub-committee on Nutrition in the company of Dr. George Bray, M.D. of U.C.L.A.* The latter, who recently resigned after less than one year as coordinator of nutrition activities with HEW, is equally distressed with the morbidity, mortality and the lack of concern with "over nutrition". HEW data documents 11 billion dollars spent in the "treatment" of obesity in 1964 with less than 1% "maintenance of weight loss" at 5 years. The cost has increased seven fold since that time with little increase in success rate -- if success is measured not in weight loss but in maintenance of weight loss -- and that is the greatest fault with the Scarsdale Diet.

Scarsdale remains an affluent suburb of New York City and Herman Tarnower, M.D. still maintains a very active internal medicine and cardiology practice in that town totalling some forty years. He has advised many patients "to eat and drink sensibly" but unlike most of us, he has written his diet suggestions down on mimeograph paper and passed them out. Requests for his guidelines increased after several newspaper and magazine articles about "SMD" and hence the

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While the diet is metabolically and nutritionally sound, it has a few flaws. Poly-unsaturated fats are prohibited (vegetable oil) and some sources of saturated cholesterol bearing animal fats recommended (cold cuts) which are high in sodium, high in fat, and low in nutrients (as compared to lean meat and fish). Disciplined measured intake is not stressed ("plenty of steak" rather than a serving limited to 4 ounces after cooking). The low calorie diet is over-stressed rather than a multidisciplinary approach in which the specific diet has an important but small role. Accumulative hard data documents that long term success is accomplished by one on one intensive efforts in behavior modifications, assertiveness training, and the positive motivating reinforcement of the aerobic target zoning approach to cardiopulmonary fitness during maintenance.

IS IT SAFE?

Absolutely.

DOES IT REALLY WORK?

Yes and no. According to personal communication with Dr. Tarnower, very few patients, if any, can follow the diet exactly and not lose weight, but two weeks is never long enough for significant weight loss in the morbidly obese (greater than 50 pounds above ideal body weight) with whom we, as physicians, should exert our greatest efforts. His "average" patient loses interest in the two weeks on and the two weeks off routine before reaching "ideal fat mass", and no hard data is available as to the maintenance of weight loss at 5 years. No uni-disciplinary approach to obesity has thus far succeeded in

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maintaining weight loss. The multidisciplinary subsets of the obesity program must be structured as the diet itself. Dr. Tarnower stated that he, himself, does not treat obese patients and has no "specific" program other than the diet itself. He also stated that "I do not recommend the diet for the morbidly obese..., we have had our greatest failure rate in this group".

WOULD YOU RECOMMEND IT?

Yes, for those for whom a multidisciplinary approach is unavailable, inappropriate or not of the patient's choosing. According to Dr. Tarnower, the diet should not be used in the treatment of morbid obestiy (but then again, a great many people only need cosmetic weight loss - 10 to 20 pounds). □

HARRISON D. WILLCUTTS, M.D.

*"The Obese Patient", Bray; Major Problems in Internal Medicine, Volume IX

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Proposals For Federalized Health Care Plans

There are three proposals presently before Congress. Briefly these

1. Carter's Health Care Proposal would be implemented in phases, with the 1st phase taking effect in 1983. It would include catastrophic coverage (over 2,5000/year/family) and improvements in health care benefits for the aged, poor and people with inadequate coverage. This would include maternity coverage and newborn coverage to age 1 year with proposed later dates extensions to child coverage through age 6 years. Financial coverage would be through:
   a. Increased private insurance by way of the third party (employer).
   b. Payment of up to 25% of the cost by the employer (unless labor contracts stipulated otherwise).
   c. Coverage of the public segment by increased federal funding. The total 1st year cost is estimated at an additional 6 billion dollars for employers and 18 billion federal funds.
2. The Kennedy Health Care for all Americans plan is for universal coverage through added private insurance and prepaid health-care plans with the employers responsible for at least 65% of the additonal costs, and employees possibly paying 35% of the costs. It would be left to labor to bargain employers for full cost coverage. The estimated additonal cost per year is 11 billion dollars for employers and 28.5 billion federal dollars.
3. The long proposal is for only catastrophic coverage (with maximum health-care costs per family per year of $2,500 - $3,500), with no new taxes. Senator Long wants employers to pay for the new mandatory coverage with the understanding that the price is passed along to the consumer as increased product and services costs.

I received this response from a presidential candidate, Howard Baker, in my quest for viewpoints regarding health-care. He hopes that "Congressional consideration of health insurance will center on those changes needed to prevent families from being bankrupted by the costs of long-term illness and to"fill in the gaps" in coverage available to the elderly under the Medicare program. Whatever health insurance legislation is considered, I believe strongly that the questions of cost and quality of care must be paramount." □

CARL JANOVSKY, M.D.

Letter To The Editor

The Physicians of the Commonwealth of Massachusetts will be required to sign a new vendor agreement in the near future. Perusal of the present agreement reveals many unrealistic requirements. As an example, Medical Records Requirements as altered in the Massachusetts Public Assistance Policy Manual effective 9/30/76, Chapter VII, Medical Care Plan, Physician's Services, Section B, Part IV, Page 1.

I. INTRODUCTION

Reimbursement for all procedures and services listed in the Medicaid Fee Schedule for Physicians and Dentists includes preparation of the patient's medical record. The medical record shall represent the verification of the nature, extent, quality, and necessity of care rendered to Medical Assistance recipients. All services billed to the Department must be substantiated by clear evidence in the patient's medical record that the services were performed. An entry may be in the form of reports of an examination, description of treatment, or findings of diagnostic tests.

II. MEDICAL RECORDS REQUIREMENTS

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The medical records corresponding to office, home, nursing home, hospital outpatient, and emergency room services billed to the Department must include data which forms the basis of the diagnostic impression or statement of the patient's problem, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits of referrals.

The medical records corresponding to office, home, nursing home, hospital outpatient, and emergency room services billed to the Department must include, but shall not be limited to:

1. date of each service
2. patient's name and date of birth
3. name and title of person performing the service if it is other than the billing physician
4. medical history
5. pertinent findings on examination
6. medications administered or prescribed, when applicable
7. description of treatment, when applicable
8. recommendations for additional treatments or consultations
9. medical goods or supplies dispensed or prescribed (if any)
10. tests and results

Data collected during previous visits with the patient (e.g. identifying data, chief complaint, history) does not have to be repeated in the medical record for subsequent visits as long as the total medical record reflects continuity of care.

The key words are "must include, but shall not be limited to". It includes office, home, nursing home, hospital outpatients, and emergency room visits. If not present one is in noncompliance of the law.

This requirement is an auditors delight. Physicians have been audited and have been penalized for failure to include all of this data. These regulations are unrealistic and illogical considering the reimbursements. The Commonwealth demands quality care at unreasonable cost. We must be aware of thisas Welfare vendors. □

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Pediatric Reflections of Child Abuse One Mans View

During the past year, "The Year of the Child", the topic of child abuse and neglect has been on television specials, hourly series, in several newspaper articles, and publicized by civic and church organizations alike.

Why; why has a nation which prides itself on its future, come to a low which is almost a national past time; that of abuse and neglect of our children. It may seem a rather strong statement to liken this problem to a national pastime, but it does seem that the frequency rate is climbing as if it were a new sport.

Each year the incidence of teenage pregnancy (600,000+) goes up; teenage divorce goes up; unwanted pregnancy (at the time of birth a large percentage of women state this child was unwanted, whether married or single), abortion (1,000,000+); inflation goes up and unemployment goes up. I'm sure one could find more examples to plug into the formula. These are but a few of the obvious commentaries of our times which have a direct relationship with the increased incidence of abuse, neglect and also of disrupting of the basic principal, "The Family".

In today's world, science has given us the possiblity of controlling the population growth by use of contraceptives; which, if not the ideal situation, at least, provides a relatively safe and effective means by which we may attain the goal of "Each child born being a wanted and a loved child."

As for this pediatrician's view, I feel that this disruption of the family unit and its way of life, which is ingrained early in our lives, has reached an all time low. How many of our children go to neighborhood schools; able to walk to and fro; not many have that luxury. Most are transported by buses away from family area across town to unfamiliar territory. This continues daily thru high school and college and culminates in the great American experience, "The Job." That uniquely American Adventure which states "to advance upward, you

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advance anywhere at anytime.'' I feel it is this loss of the closeness of the family unit once had and now has all but been Blitzkreged to extinction by todays Modern society that probably contributes more than most to the problem.

The young parents who have a baby today find themselves often without friends and family and cannot look for support when they have simple questions and problems of child rearing. They often flounder in a sea of colic, diarrhea, fever, feeding technique, growth and development problems. Not only are todays parents away from family supportive measures; but, also less and less of these parents have been themselves exposed to babies during their growth; such as infant siblings and baby sitting. As a consequence, they have no knowledge or experience to fall back on when the early problems begin with their own children.

There are many definitions of child abuse and neglect, but a nice concise definition was given a number of years ago by Francis Sargent, former governor of our state, ''A family crisis which threatens the physical and emotioned survival of a child.''

Statistical evidence of abuse varies as the literature one reads. A good estimate is 380/million population in the United States. This equals 70,000 + reported cases. The actual cases unreported exceed 4-5 times this number. Fifty percent of these children are under 5 years, seventy five percent are dead on arrival to the hospital. This number alone is sobering--2,100-6,000 dead each year. Another fact not well appreciated, I'm sure, is that at least 10% of all pediatric emergency room visits are due to abuse and neglect related problems.

In this article, I do not intend to make an indept discussion of how to diagnose and treat the children of abusive and neglectful parents, but bring out only the early signs we look for. For it is only this way that the death rate and the rate of irreparably physical, emotional, and mental handicapped children can be lowered, and hopefully, idealisticly, be eliminated.

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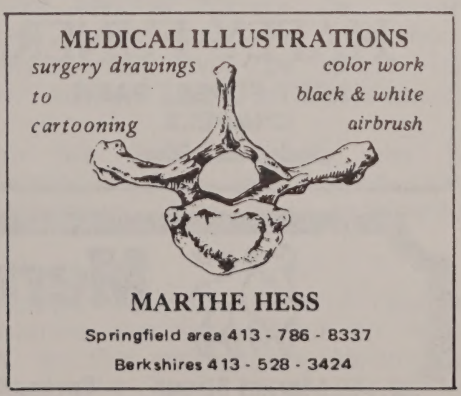
The**History**, is the area in which most of the abuse should be picked up: the parent who delays hours to days for treatment; the injury that is blamed on a person incapable of defending themselves (a young sibling), the explanation of injury does not fit the actual physical findings of the child; the parents may be very defensive and resent inquiry as to the present "injury" or the past medical history. The parents' background can give one clues, they are usually person of low self esteem, and socially isolated. They usually show a picture of deprivation, abuse and neglect as a child themselves.

The inter-action of the parent and child is an important guide to the diagnosis. The parents usually view the child with unrealistic goals, and view them with dispassionate behavior. The child realizing these facts will seek others for comfort and rarely complains when the parent leaves the examining area. They may assume the "fright and flight" position whenever placed in a one to one situation with an adult.

In the physical examination one makes not only specific observations, but general ones, such as: weight, height, cleanliness and dress. The common areas to observe for injury are the skin (burns, lacerations, abrasions, bruises,) the Head, for hematoma or fracture, for this single area accounts for over 20% of the abused findings. Fractures, in other areas of the body and of different age, this slows multiple times and frequency of injury. Important findings would be spiral fractures in the under three age bracket, rib fractures, periosteal avulsions, metaphyseal bucking, impaction and bone chips indicative of repeatitive injury. Intra Abdominal injury is less common, but obviously could be life threatening.

The management of abuse depends a great deal on the extent and the severity of injury involved. Where simple referral to a social agency may suffice the young parent with parenting problem, the severely injured or neglected child may need hospitalized care with agency referral while in the hospital setting. In our area of the hospitalized care with agency referral while in the hospital setting. In our area of the State the agency is the Child Protective Unit, Department of Public Welfare. Their address is 140 Chestnut Street, Phone 781-0881.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At the present time, we as physicians, are mandated by law to report any suspicion of abuse or neglect. Not just the documented case, but any reasonable clause case. It is then the state's responsibility to investigate the complaint. Being mandated along with other professionals, it is a criminal offense not to report; punishable by a fine of $1,000 and criminal action. In the State of Massachusetts these penalties vary from state to state; from no penalty to one year and $1,000 with possible loss of license.

What about treatment of parents of abused children? Following the investigation and disposition of the case there are numerous ways for the parents to attain help in coping with the every day crisis which plague us all. There are psychiatric services, which most cannot affort; Families anonymous, Parents anonymous, Crisis center nurseries, Day care centers and lay Therapist programs.

Addresses for two of the groups which concerns itself with the protection of children and treatment of parents are:

Parents Anonymous
National Headquarters
2009 Farrell Avenue
Redondo Beach, CA 90278

Child Protective Team
Colorado General Hospital
4200 East Ninth Avenue
Denver, CO 80220

In summary, although the reasons given for child abuse are as varied as the color in the light spectrum; I feel that the mechanization of our society has dehumanized and depersonalized our civilization such that when a frail and fragmented family unit finds itself in a corner, it lashes out and often the children of these families bear the brunt of its rath. □

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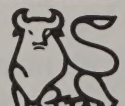
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Executive Committee
January 15, 1980

The Executive Committee of the Hampden District Medical Society met on Tuesday, January 15, 1980 in the Conference Room.

Present were Drs. Navazio, Walthall, Remsberg, Flahive, Stoddard, Siragusa, Corsaro and Mrs. Purdy.

Absent were Drs. Bagamary, Rich, Zadworny, Dasco, Fitzpatrick and Bloom.

Dr. Garry Hough was present to discuss membership both in the American Medical Asociation and the H.D.M.S. There is a need for recruitment and an increase of members yearly for an ongoing society. He is very interested in recruiting members for the American Medical Association to increase representation in the House of Delegates from the state of Massachusetts. A suggestion from the Committee is to have a Job Description written for Councilors outlining their duties and an evaluation of attendance at pre-council and council meetings. Another suggestion is having Councilors selected from specialty groups and hospital groups. Dr. Hough recommends 6-8 represent hospitals, 10 represent specialty groups and the rest elected at large. The committee asked Dr. Hough to write this job description. Hampden is entitled to 24 councilors.

The minutes of the December meeting were mailed out and the Executive Committee accepted them as written.

CORRESPONDENCE

A letter from Dr. Kruger was read regarding HMO's advertising and using premiums paid by individuals to BC-BS to this advertising. This very question has come to the attention of the Massachusetts Medical Society through the Hampden District Medical Society and is to be considered at the February meeting of the Council. A copy of this will be sent to Dr. Kruger.

A Special Report in the form of a letter from Channel 22 was sent to the Hampden District Medical Society. Dr. Bloom Public Relations Councilor asked if this could be published. The committee agreed and membership will be asked for comments. Permission to publish will be asked of Mr. Putnam of Channel 22.

An informational notice from Mr. Joseph Roche who is running for Chairman of the Democratic Party in Massachusetts was sent to the committee members. This was considered informational.

OLD BUSINESS

An answer from B.J. Anderson, Assistant General Counsel of the American Medical Association was read about an Arbitration Panel article that was in the newspapers concerning Lawyers. Ms. Anderson answered this saying that State bar

associations are arms of the State Supreme Courts and are exempt from alleged violations of the antitrust laws as state agencies.

A response from Dr. James Allan about Blue Shield paying for laboratory studies was read. A directive was sent to all members on October 12, 1979 stating that lab studies must be related to the disease present or being investigated.

The problem of the old 30% cut in Medicaid problems was discussed. On Friday, January 18th a meeting of the representatives from the four Western Massachusetts counties will meet to discuss this. In the Newsletter going to the membership a sample letter will be sent pleading with members to write their Legislators NOW and ask for repeal. Medical Examiner Assistants are needed in some communities. This will be printed in the Newsletter.

There was no recent report on the status of the Springfield Academy of Medicine.

Dr. Navazio had to leave to see a patient and Dr. Siragusa presided.

NEW BUSINESS

Dr. Siragusa pleaded for better communication between the Massachusetts Medical Society and the county societies. This will be studied further by Dr. Siragusa.

Dr. Siragusa also stated that the committees are to be revamped and reports should be printed periodically in the Hampden Hippocrat.

The Insurance Committee has not had another meeting about Dr. LaMarche's letter of October 19th. Dr. Navazio will be asked to call Dr. Centeno and ask for action on this request.

A $25 donation to Shriners Hospital was made in memory of Mrs. Mildred Lund Martin's son Robert who was recently killed in a truck accident.

The Board of Registration of Medicine reported to Mrs. Purdy that recertification licenses will be 4-6 weeks late arriving to members. □

WILLIAM W. WALTHALL, M.D.
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BY-LAW Changes

These amendments to the By-Laws of the H.D.M.S. are to be voted at the next meeting of the membership which will be held on Tuesday, April 29, 1980 at Storrowton Tavern.

Chapter VII, Section 16 Peer Review

The By-Laws Committee recommends that the Peer Review Committee be renamed the Committee for Disabled Physicians as this title more nearly reflects the function of the committee. This title conforms with the corresponding committee of the Massachusetts Medical Society.

Chapter VII, Section 2

The By-Laws Committee recommends that the word "Discipline" be removed due to the name change of the Board of Registration of Medicine. □

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